

WRMA

Walter R. McDonald & Associates, Inc.

FINDINGS FROM THE

SERVICE AREA 6 FOCUS GROUPS

CONDUCTED FOR THE MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN
IN LOS ANGELES COUNTY

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I. Introduction

The Los Angeles County Department of Mental Health (LACDMH) is engaged in an intensive, inclusive, and multi-faceted approach to developing the County's Prevention and Early Intervention (PEI) Plan to be funded through the Mental Health Services Act (MHSA) enacted by California voters in 2004.

The focus for developing the PEI Plan is at the Service Area level, utilizing informational meetings, key stakeholder interviews, focus groups, and community forums in each of the eight geographic areas of Los Angeles County. Because each Service Area has distinct and varying populations, geography, and resources, it is critical for PEI services to be specific and responsive to regional and community-based needs.

The California Department of Mental Health (CDMH) has defined *mental health prevention* as reducing risk factors or stressors, building protective factors and skills, and increasing support to allow individuals to function well in challenging circumstances. Whereas, *mental health early intervention* involves a short duration (usually less than one year) and relatively low-intensity intervention to measurably improve a mental health problem or concern early in its manifestation and avoid the need for more extensive mental health treatment or services later.

In addition, CDMH has targeted five community mental health needs, six priority populations, and six statewide efforts for the PEI Program, and has identified seven sectors that counties must partner with to develop their PEI Plan.

This report presents the findings from the Focus Groups conducted in Service Area 6. Each service area will receive a report of the findings specific to the focus groups selected to speak on its behalf. In addition, a comprehensive final report will be produced presenting aggregate findings across all of the focus groups conducted in Los Angeles County.

II. Methodology

Participants

Each focus group was comprised of no more than 10 participants. Participants were drawn from existing groups/agencies for the purpose of participating in a discussion about the mental health service needs, barriers, and strategies in their respective communities.

- As with the Key Individual Interviews, the focus groups were selected based on Service Area representation and the categories of MHSA age group, sector, priority population, and key community mental health needs for PEI. Utilizing recommendations made from LACDMH District Chiefs, Service Area Advisory Committee (SAAC) members, and other stakeholders throughout the county familiar with the categories, LACDMH selected focus groups that qualified in at least two PEI categories.
- LACDMH identified a focus group coordinator from each community group/agency selected. The focus group coordinator sought participation in the focus group from among the agency's membership. Focus group coordinators were asked to identify and invite a diverse group of participants who could speak about service needs, barriers, and recommended strategies for their Service Area.

Participating Agencies

A total of 51 individuals from the following six agencies in Service Area 6 were asked to participate in their respective focus group:

1. Center for Childhood Loss and Grief, Hathaway-Sycamores Child and Family Services;
 2. Crystal Stairs, Inc.;
 3. Ethiopian Church Public Mental Health Forum;
 4. Kinship in Action, Community Coalition for Substance Abuse Prevention and Treatment;
 5. SHIELDS for Families, Inc.; and,
 6. Watts Healthcare Corporation, HIV/AIDS Provider Network.
- The six participating agencies from which the focus groups were drawn have been in existence between one and ten years. Four of these agencies support up to 50 or more members; the other two did not provide this information.
 - Across the six participating agencies, members ranged in age from 16 to over 60, with one participating agency represented by adults only; and two participating agencies represented by transitional-age youth in addition to adults and older adults.
 - With respect to the ethnic composition of the six participating agencies, all six represent the Latino/Hispanic community; five also represent the African American community; three represent the Caucasian community; one also represents Asian Pacific Islanders; and another indicated representing “other” ethnic groups.
 - Finally, the following community sectors in Service Area 6 are represented across the six agencies: Community Family Resource Centers, Education, Employment, Health, Individuals with Serious Mental Illness, Law Enforcement, Media, Mental Health Service Providers, Social Services, and Underserved Communities.

Procedures

Each focus group coordinator worked closely with a member of the contracted consulting team to arrange focus group dates, times, and locations.

The focus groups were conducted at the organizations or agencies representing the focus group participants or other community-based locations. The focus groups were audio recorded and took about two hours to complete. Nine key questions, some of which contained sub-questions, were posed to focus group participants. The questions were designed to produce information needed to inform the PEI planning process. A copy of the Focus Group Guide can be found in **Appendix A**.

Facilitators representing LACDMH at the focus groups as a neutral third party included a team of three staff members from Walter R. McDonald & Associates, Inc. (WRMA) and their subcontractors, EvalCorp Research & Consulting, Inc. and Laura Valles and Associates, LLC. One team member facilitated the focus group, another observed and documented notes, and a third recorded participants’ responses on flip charts, which participants could refer to throughout the focus group.

Focus group documentation included: a Focus Group Profile, a Focus Group Participant Profile, a signed Consent Form indicating that the focus group would be audio recorded, the observer’s electronic notes, the paraphrased responses from participants, an audio recording of the focus group, and a transcript of the focus group developed from the audio recording. A report was written by the

focus group team observer, summarizing the group's responses to the questions. Information from each focus group was coded so that the data could be analyzed and presented in summary format.

III. Knowledge of the PEI Planning Process

Participant Participation in the PEI Planning Process (Q1)

The first question(s) that focus group participants were asked to answer was "Have you or your group taken part in the Los Angeles County Department of Mental Health's PEI planning process? And, if so, how?" Of the 51 focus group participants, only two participants from one of the six focus groups had participated in the PEI planning process.

IV. Service Area and Priority Population Representation

Service Area (Q2)

When focus group participants were asked which service area they represented, a number of participants represented multiple service areas. Of a total of 51 participants, 39 indicated that they represent Service Area 6; 8 participants represent Service Area 8; 6 participants represent Service Area 7; 1 represents Service Area 5; and 11 represent all service areas. Participants in the Ethiopian Church focus group wanted to note that while the group primarily represents the county as a whole, some participants also specifically represent Service Areas 5, 6, and 8.

Priority Populations (Q2a)

The CDMH has identified the following six priority populations for PEI services: 1) Underserved cultural populations; 2) Individuals experiencing the onset of serious psychiatric illness; 3) Children and youth in stressed families; 4) Trauma-exposed individuals; 5) Children at risk for school failure; and, 6) Children and youth at risk of or experiencing juvenile justice involvement. Focus group participants were asked to select the priority populations they represent. As shown in **Table 1**, of the six priority populations, the highest proportion of participants represent Underserved cultural populations at 84 percent. Close to three-quarters of the participants represent Individuals experiencing the onset of serious psychiatric illness (73%) or Children and youth in stressed families (71%). Trauma-exposed individuals, Children at risk of school failure, and Children and youth at-risk of or experiencing juvenile justice involvement are represented by 69 percent or less of participants.

Table 1: PEI Priority Populations

PEI Priority Populations	Number of Participants	Percent of Participants (n=51)
Underserved cultural populations	43	84%
Individuals experiencing the onset of serious psychiatric illness	37	73%
Children/youth in stressed families	36	71%
Trauma-exposed individuals	35	69%
Children at- risk of school failure	34	67%
Children/youth at-risk of or experiencing juvenile justice involvement	28	55%

V. Community Mental Health Needs and Impacts

Mental Health Needs in the Community (Q3 and Q3a)

Each focus group participant identified the mental health needs in their community based on five MHSA categories: 1) Disparities in access to mental health services; 2) Psycho-social impact of trauma; 3) At-risk children, youth, and young adult populations; 4) Stigma and discrimination; and, 5) Suicide risk. Of the six focus groups representing Service Area 6, three-quarters of the participants indicated that At-risk children, youth, and young adult populations (76%) and Disparities in access to mental health services (75%) are key needs in the communities they serve (see **Table 2**). Two other highly indicated needs are Stigma and discrimination and Psycho-social impact of trauma (71%). Almost 1 in 2 focus group participants (49%) identified Suicide risk as a high need in their communities.

Table 2: PEI Mental Health Needs

PEI Mental Health Need	Number of Participants	Percent of Participants (n=51)
At-risk children, youth, and young adult populations	39	76%
Disparities in access to mental health services	38	75%
Stigma and discrimination	36	71%
Psycho-social impact of trauma	36	71%
Suicide risk	25	49%

When asked to identify the top three mental health needs from among the list of five determined by CDMH, Disparities in access to mental health services and stigma and discrimination were given equal weight as top priority mental health needs by four of the six focus groups (see **Table 3**). A similar result occurred for the second priority mental health need (i.e., At-risk children, youth and young adult populations, psycho-social impact of trauma, and suicide risk were each selected by three of the five focus groups creating a three-way tie for the second priority).

Table 3: Priority PEI Mental Health Needs

Priority PEI Mental Health Needs	Number of Groups (n=5)	Priority
Disparities in access to mental health services	4	1
Stigma and Discrimination	4	1
At-risk children, youth, and young adult populations	3	2
Psycho-social impact of trauma	3	2
Suicide Risk	3	2

*One focus group did not prioritize the mental health needs.

Impact of the Mental Health Needs on the Community (Q4)

As presented in **Table 4**, focus group participants reflected upon and relayed the negative impact that the unmet mental health needs discussed in the previous section have had on their communities. The four most highly mentioned impacts encompassed concerns about the social and economic conditions

“As far as issues like homicide, suicide, divorce, incarceration, economic disparity, they’re unable to work as a result. As a matter of fact, they become a burden on the state because they will end up getting some sort of help, probably when it’s too late. So, if we had ... early prevention, if we had help, none of these things probably would have happened.”

in communities, service access, mental health issues affecting community members, and the types of trauma to which children, families, and communities are exposed in Service Area 6.

A significant portion of the discussions about the impact of mental health needs on communities underscored the poor social and economic conditions under which community members live. Focus group participants stated that they see homelessness, unemployment, prostitution, criminal activity, drug sales, financial disparities, escalating school drop out rates, and general stress in their communities. One focus group emphasized

that families are experiencing not only one of these stressors, but multiple and intersecting stressors. For example, a family may be struggling financially while at the same time coping with a newborn, a mother with postpartum depression, another child acting out in school as a result of witnessing a recent shooting in the neighborhood, and a father’s alcoholism and frequent bouts of unemployment.

Compounding the communities’ social and economic circumstances is the lack of access to mental health services, as well as other health and social services. With respect to mental health services, participants particularly noted a lack of access to counseling services and other services for young adults. Stigma also plays a significant role in accessing services. In the Ethiopian community, mental health is a taboo and thus the families tend to hide mental health needs and try to handle them on their own, without seeking services at all. Fear of the Immigration and Naturalization Service also prevents people from accessing services. Furthermore, focus group participants pointed out that when community members do seek services they are confronted by unskilled, unqualified, and culturally unaware providers, further perpetuating the stigma they experience and altogether discouraging them from seeking assistance.

The rise in mental health issues is another impact on communities, especially issues of substance abuse along with anxiety due to trauma-exposure. As revealed by participants, substance abuse is a generational issue in their communities that has been left untreated and often leads to aggression towards children. They further relayed that substance abuse issues in the community, particularly drug abuse, have exacerbated mental health problems to crisis levels. The high rates of drug and alcohol abuse also contribute to the level of gang activity, number of homicides, and incidents of domestic violence that are occurring in Service Area 6 communities.

“Everyday at Jordan High School I see kids having kids and they are the kids of the folks who have struggled with mental health and substance abuse for decades. It breaks my heart to see kids repeat the same maladaptive behaviors of their parents.”

All of the community impacts discussed thus far have a cumulative effect on the communities represented by the focus group participants, resulting in the further disintegration of community and family and reinforcing feelings of hopelessness and helplessness.

Other community impacts cited, but not mentioned as highly as those reported above were:

- Medication management and other issues such as overuse of medication, fears of taking medication due to stigma, and lack of education about mental health.

- Poor service quality in terms of misdiagnoses, poor diagnostic and assessment tools, and non-responsiveness to consumers' needs for alternative treatment modalities.
- Negative behavioral and social outcomes including loss of self-esteem, poor choices, and long-term behavioral problems.
- Lack of awareness about the signs and symptoms of mental illness as well as how to access needed services.
- Unaddressed mental health problems that are becoming worse.
- Unaddressed health care issues that are having an effect on mental health issues.
- Insensitivity of mental health professionals to the larger social and environmental context in which consumers live.
- Schools are often ill-equipped to lessen mental health problems, and sometimes may even make it worse.
- Service needs are not well coordinated with social workers.
- Mental health professional staff often is not skilled enough to provide quality service. Many are interns and on short-term placement, reducing their ability to establish a comprehensive understanding of consumers' mental health needs.

Table 4: Ways in which Mental Health Needs Impact the Community

Community Impact	Number of Mentions
Social/Economic Conditions	16
Access Issues	10
• General Service Access	3
• Stigma and Discrimination	3
• Available Services/Capacity	1
• Cost/Insurance/Medi-Cal/Eligibility Criteria	1
• Service Linguistic/Cultural Competency	1
• Transportation	1
Mental Health Issues	10
• Substance Abuse	5
• Depression/Suicide Risk	2
• General Mental Health Issues	2
• Trauma/PTSD/Anxiety	1
Community/Family Violence/Abuse	9
Community/Family Breakdown/Hopelessness	5
Medication Issues/Management	5
Service Quality	5
Behavioral/Social/Emotional Issues/Outcomes	4
Juvenile Justice Involvement/Incarceration	4
Negative/Risky Behavior	4
Outreach/Education/Awareness-General	3
Unaddressed Conditions/ Higher Levels of Care	3
Academic Outcomes	2
Generational Cycle	2
Health Care Issues	2
Sensitive Staff/Can Relate	2
Immigration/Cultural Matters	1
School Issues	1
Service Integration/Continuity of Care	1
Staff Quality	1
Other	3

VI. Existing and Needed Prevention Services/Resources

Existing Prevention Services/Resources (Q5)

The following is a listing of all the existing prevention services identified by participants across all six focus groups. One focus group pointed out that they know prevention services exist in their community, but find them difficult to identify and become eligible for services. One focus group stated that no mental health prevention services exist in its community; instead there are natural systems in place that provide prevention.

“There are things out there, but how do you prevent the children from anything when there is no real prevention care?”

- Adult school, offers courses to fulfill high school graduation requirements with shorter schedules to accommodate working young adults.
- AIDS education programs (specifically through Charles Drew Hospital).
- Bienestar, particularly programs on AIDS health education and awareness.

- Boys and Girls Club.
- Center for Childhood Grief and Loss.
- Child Guidance Center.
- Children's Institute International (CII).
- Churches, especially large churches that provide referrals, counseling, and youth groups/activities.
- Community Associations, act in many socially supportive capacities.
- Community Centers, such as El Nido, provide parenting classes and teen pregnancy assistance.
- Community Coalition, specifically its support and training of foster parents.
- Cultural and Sports Events, draw thousands of Ethiopians from North America.
- Department of Children and Family Services Hotline and Medical Hubs.
- Didi Hirsch Community Mental Health Center.
- DMH Psychiatric Emergency Team (PET).
- Doctors within the community, who include baby showers as part of the teen parenting classes they teach.
- Doctors, such as pediatricians who can answer parents' questions and make referrals during routine check-ups.
- Domestic Violence Shelters, provide referrals and counseling services.
- El Nido Teen Programs, such as school tutoring and prenatal services.
- English as a Second Language (ESL) classes at schools and local libraries.
- Family Pact, provides free counseling for teens to prevent pregnancy.
- Family Services, deals mostly with adults with mental health problems.
- HealthNet's, "LA Care" program, donates diapers and formula for clients (works in collaboration with Shields for Families).
- Healthy Families.
- Healthy Start and New Start, part of Shields for Families.
- Homeboy Industries, helps with gang intervention and job readiness.
- Hotlines, for runaways, abuse, and pregnancy.
- Hubert Humphrey's Health Clinic.
- Joint Efforts, provides substance abuse counseling and assistance.
- Jordan High School's Health Clinic.
- Kaiser Permanente.
- KATC, General Hospital.
- Kedren Community Mental Health Center.
- Latino Resource Organizations:
 - El Nido; and,
 - Proyecto del Barrio, provides health education programs for teens, substance abuse prevention, and birth control.
- Medi-Cal.
- Needle exchange programs that prevent others from getting infected.
- Northeast Valley Health Corporation.
- Parenting Institute, offers parenting classes.
- Parks and Recreations, offers after school academic, enrichment, and athletic programs designed to help youth achieve in school and stay out of gangs.
- Planned Parenthood, offers a free clinic, peer counseling, health care, birth control, physical check ups, etc.).
- Queens Care Family Clinic, provides free services at low cost for pregnant teens.

- Regional Center.
- Religious Celebrations, draw Ethiopians from all parts of LA County.
- Safe Haven, a baby drop-off program at hospitals and fire stations.
- Schools with different services.
- Spectrum, particularly the community education component.
- Sports Clubs that young people access.
- St. Anne's Maternity Home, offers shelter and all types of help for teenage pregnant girls, including parenting classes and training.
- Faith-based groups that come together on weekends.
- Support groups.
- Teen Parenting classes.
- Ethiopian community, offers nurturing and other support services.
- Watt Healthcare Corporation.
- YMCA.
- 12-step Programs:
 - Alcoholics Anonymous Programs.
- 211 Call Centers.

Needed Prevention Services/Resources (Q5a)

All six focus groups identified a number of needed prevention services and/or resources as reflected by the list below. The needed prevention services are organized by type of service/resource and listed from highest to lowest number of needed services/resources cited under each service/resource type. One person simply suggested services that address all key mental health needs in the community.

"You have the answers right here. The Key Mental Health Needs -- take care of all of these and we got it."

Specific Services and Resources including Counseling and Support Groups

- Services for children and young adults.
- Services for parents with children with disabilities.
- Youth services that offer recreational and educational activities, such as DARE, that involve law enforcement personnel who can educate youth about the consequences of their actions and expose them to other alternatives.
- Teen parenting programs, particularly for teen fathers.
- Boys and Girls Club.
- Head Start Programs.
- YMCAs.
- After school programs.
- 12-step programs for substance abuse-involved youth.
- Drug abuse prevention programs.
- Pregnancy prevention programs that teach teens what it is like to have a baby.
- Life skills programs.
- Referral services that are timely and appropriate.
- Supportive services, that discuss "life issues," such as "What is it like to be exposed to family violence at home?" Or, "When Dad is an alcoholic...?"
- Counseling services.
- Support groups.

"Head Start teaches [children] things before they get to school, because it will get them interested in learning at a young age."

- Drop-in counseling centers.
- Adult self-help groups and peer mentors.
- Self-help groups for youth and young adults that provide young people with opportunities to talk about their problems and alternatives to gang violence.
- Safe and friendly counseling programs for LGBT youth, particularly African-American and Latino youth.

Specific Strategies and Approaches

- Screening tools used by primary health clinics to determine patients' mental health needs.
- Assessments and evaluations of all children removed from their parents.
- Quality assessment and diagnosis for youth 13 and over.
- Early teen pregnancy resources, including hotlines.
- Multi-purpose community-based services providing culturally appropriate case management, and assistance on how to navigate the system and gain entry to mental health services as well as other social services. Approach includes providing services to a variety of ages, conditions, and diagnoses. Ethiopian community strongly supports this approach.
- Health insurance for 12 and 13 year old youth who have a tendency to fall through the cracks.
- Birth control education for youth.
- Empowering parents with special needs to speak honestly and publicly about mental health issues.
- Groups providing opportunities for community members to support one another through child watch or childcare.
- Support strategies that use a "helping hands" or a "village" concept approach where community members, former clients, teachers, and parents participate and serve as resources to others.
- Community activities that attract youth and deter them from other aberrant behaviors.
- Entertainment and other social activities for special needs children and those with disabilities.
- Creative and domestic arts opportunities (e.g., sewing, knitting, crocheting, cooking, and photography).
- Dance, art, or computer classes for youth and adults.
- Arts programs including music and dance.
- Sports.
- Free local or neighborhood-based tutoring programs.
- Academic tutoring for youth 13 and over.
- Reading programs, libraries, and bookstores.
- Opportunities for learning via home study programs or learning centers, such as the Educational Partnership High School. This approach allows some students to operate outside the traditional school structure in order to graduate.

"There are not enough! I love Borders bookstores and have to go all the way to Long Beach to get to a bookstore or a really good library."

Outreach, Education, and Awareness Services and Resources

- General outreach, education, and awareness.
- Education throughout the community about available prevention services.
- Accessible information about where community members can receive needed mental health services.
- Advertisements and outreach of existing programs.
- Parent and teacher trainings on how to recognize mental health concerns and needs.
- Parenting programs to prevent child abuse and support the healthy socio-emotional development of children.

- Educational programs and campaigns that work to reduce the stigma associated with mental illness.
- Education in schools on how to address early signs of mental health issues.
- Information dissemination in churches and education for community and church leaders.

Services and Resources that Increase Access

- More services and resources within the community to meet the needs of local members.
- Services that are stigma reducing, not stigma inducing.
- Increased efforts to reduce stigma.
- Approaches that address stigma prior to addressing access to services.
- Improved access to programs.
- Available transportation.
- Language proficient services, including materials and treatment in Amharic and other Ethiopian languages.
- Services that support community members who are not able to read or write.
- Culturally competent child development providers with quality training who can relate to the service population and community at large.
- Programs that provide mental health related services on evenings and weekends.

Location-based Services

- Jail-based rape prevention and education programs for youth who are incarcerated.
- One-stop community centers in strategic locations.
- Full service, community-centered, social service drop-in centers that offer mental health services where people can come in and share their needs, and receive services and referrals.
- Community-based crisis centers.
- Community-based grief and loss centers.
- Youth-focused community-based centers that offer activities for children and give parents peace of mind, such as they YMCA-type model.

Staff and Provider Education, Training, and Recruiting

- Education and awareness about mental health for community leaders as well as general community members.
- Efforts to recruit and train community counselors who are community-based, rather than importing them from other communities.

Safety/Stability

- Safe passage on the streets for children.
- Safe neighborhoods.

Quality Staff

- Experienced, knowledgeable, and informed social workers.

Service Collaboration, Partnerships, Teams

- Collaboration and coordination of existing services.

Other

- Affordable child care.
- Less violence in the media.

Priority Prevention Services/Resources (Q5b)

When three of the six focus groups were asked to prioritize the needed prevention services they had listed in response to the prior question, they selected three priority services, as presented in **Table 5**. Three focus groups did not prioritize prevention services, either due to time constraints or an inability among the group to select top priorities.

The priorities identified by three of the six groups reflected prevention services that would:

- Raise awareness about mental health services.
- Reduce stigma and discrimination.
- Provide services of high quality that are holistic in their approach to diagnosing and treating consumers.
- Offer specific services such as teen parenting prevention services.
- Create a Community Center at large, and in the Ethiopian community, at which multiple services are offered across sectors.

An additional priority cited by one of the focus groups was the need to utilize the media more in outreach efforts and offer more life skills development programs. Please note that the priorities listed in **Table 5** are not listed in rank order.

Table 5: Priority Prevention Services/Resources (n=3)

Focus Group	Priority 1	Priority 2	Priority 3
Crystal Stairs, Inc.	Teen parenting prevention services.	Increasing funding.	Increasing staffing levels.
Ethiopian Church Public Mental Health Forum	A Community Center in the Ethiopian community.	Reducing stigma and discrimination.	Increasing education and awareness.
Watts Healthcare Corporation, HIV/AIDS Provider Network	Services that treat the individual holistically.	Services with high quality care.	All needed services should be addressed.

Note: Priorities not listed in rank order.

Locations for Prevention Services/Resources (Q5c)

Table 6 presents the locations at which the focus group participants would like to see prevention services offered. Three focus groups did not discuss locations for prevention services.

As shown in the table, two of the three responding focus groups cited schools as a viable location for mental health prevention services. The Ethiopian Church focus group pointed out that Little Ethiopia is a good location for services in their specific community. The other focus groups identified homes, health clinics, parks and recreation areas, as well as locations that preserve confidentiality and remove stigma.

Table 6: Prevention Service Locations

Prevention Service Locations	Number of Groups (n=3)*
Schools	2
Community Center	1
Grassroots community organizations	1
Health Clinics	1
Little Ethiopia	1
Locales close to client homes	1
Parks and recreation areas	1
Places where mental health access maintains confidentiality and minimizes stigma	1

*Three focus groups did not provide preferred locations for prevention services

VII. Existing and Needed Early Intervention Services

Existing Early Intervention Services/Resources (Q6)

The following is a listing of all the existing early intervention services identified by the participants across the six focus groups. Among the six focus groups, one group stated that there were no available early intervention services in their community.

- After school Programs (e.g., Beyond the Bell).
- Augustus Hawkins Mental Health Center.
- Bienestar.
- Boys and Girls Club.
- Child Development Centers, link families to mental health related services.
- Churches, offer some services and supports.
- City of Los Angeles Gang Intervention Programs.
- Counseling.
- Deputy Auxiliary Police Services (DAPS).
- Domestic Violence Shelters.
- El Nido, provides gang prevention services.
- Head Start Programs.
- Health Clinics.
- Housing and Urban Development, offers programs for children with developmental disabilities.
- Individualized Education Plan (IEP).
- Jeopardy.
- Jordan High School's Health Clinic.
- Juvenile Impact Program.
- Kaiser Permanente, provides support groups and mental health services.
- LA's Best.
- Latchkey Kids.
- OASIS.
- Parents who can recognize risk factors.
- Parks and Recreation Centers, offer services and provide referrals to appropriate services.
- Pastors/Churches.
- Planned Parenthood.

- Police Department Programs:
 - Police Athletics League (PALS).
- Psychiatric Evaluation Teams.
- Ranchos los Amigos.
- Regional Centers, for children and families with disabilities.
- School counselors.
- Section 504 Services.
- Shields for Families.
- Spectrum.
- Watts Healthcare Corporation.
- Whittier Job Training Program.
- WIC.
- Youth Sports Programs.
- 12-step Support Groups:
 - Alcoholics Anonymous;
 - Al Anon; and,
 - Narcotics Anonymous.
- 211 Call Centers.

Needed Early Intervention Services/Resources (Q6a)

All six focus groups identified a number of needed early intervention services and/or resources as reflected by the list below. The needed early intervention services are organized by type of service/resource and listed from the highest to the lowest number of needed services/resources cited under each service/resource type.

Specific Services and Resources including Counseling and Support Groups

- Services for seniors and older adult populations, including senior centers and transportation services.
- Services for young children with signs of mental health issues, such as autism, to prevent the conditioning from worsening.
- 24-hour emergency services such as those provided by Martin Luther King Hospital.
- Therapeutic nurseries focused on working with children on a one-on-one basis.
- Boy Scouts.
- Boys and Girls Clubs.
- Summer camps for children.
- YMCA.
- Counseling services in general.
- Quality, low cost counseling services with qualified providers (i.e., culturally representative and competent, bi-lingual, well trained, etc.).

Services and Resources that Increase Access

- Expansion of existing programs to accommodate the high need that is currently being experienced in the community.
- Economic supports and health insurance for families living just above poverty, living from paycheck to paycheck, and who do not qualify for services.
- Geographically accessible services within the community.
- Transportation.
- Culturally and linguistically competent services.
- Culturally competent mental health professionals.

- Timely services that provide immediate intervention.

Specific Strategies and Approaches to Service Delivery

- Expertise to address the needs of children with multiple and/or complex mental health issues.
- Assistance from the County to identify existing and appropriate services.
- Methods of identifying the onset of mental health issues, particularly in the Ethiopian community where community members often experience economic and social stress that leads to mental health issues.
- Male mentors who can help boys whose fathers are absent.
- Emphasize the pursuit of higher education and juvenile violence prevention, such as DARE.
- Affordable gyms where people can go, such as Oscar de la Hoya's.
- Affordable sports leagues for youth.

Outreach, Education, and Awareness Services and Resources

- Outreach and funding for existing programs.
- Community education on mental health issues, symptoms, and signs.
- Mental health promotion at social, sports, and community events, such as the Annual Ethiopian Soccer and Cultural Event.
- Outreach to community members at community forums.

Location-based Services

- Local Regional Centers.
- Community centers that offer a wide-range of services without eligibility restrictions for undocumented individuals.
- Low cost, community-based programs for youth that are safe and productive.
- After school programs.

Service Integration and Continuity of Care

- More and better coordinated services overall.
- Coordinated and integrated services in one location.

Funding and Resources

- Increased funding to sustain existing services and implement new programs.

Staff and Provider Education and Training

- Retraining of police officers to communicate more effectively with community members in lieu of a punitive approach.
- Training on mental health issues for community groups such as churches, support groups, and community leaders.

Other

- Affordable day care.

Priority Early Intervention Services/Resources (Q6b)

When two of the six focus groups were asked to prioritize the needed early intervention services cited above, they selected three priority services, as shown in **Table 7**. One of the six focus groups was unable to come to consensus on how to prioritize the needed services they had identified. Three additional focus groups were not asked by the focus group facilitator to prioritize early intervention services. The priorities identified by two of the six groups reflect early intervention services that would:

- Provide geographically accessible, affordable services for low income families.
- Ensure that services are ethnically, culturally appropriate and sensitive to the community.
- Expand upon existing services to better address and meet the mental health needs in the community.

Please note that the priorities listed in **Table 7** are not listed in rank order.

Table 7: Priority Early Intervention Services/Resources (n=2)*

Focus Group	Priority 1	Priority 2	Priority 3
SHIELDS for Families, Inc.	Affordable services for low income families.	Services that are geographically accessible.	Compatible community-based service providers who are considerate of the ethnic, cultural, and educational background of the community.
Watts Healthcare Corporation, HIV/AIDS Provider Network	Additional resources to expand existing services to better address the needs of their clients and community.	No response.	No response.

Note: Priorities not listed in rank order

Locations for Early Intervention Services/Resources (Q6c)

Table 8 presents the locations at which focus groups would like to see early intervention services offered. Two of the six focus groups provided locations. In four of the six focus groups, service locations were not discussed.

The participants of the two responding focus groups suggested similar locations to those suggested for prevention services, with the exception of the addition of churches, hospitals, and homes. The same two focus groups suggested schools as a location for both prevention and early intervention.

Table 8: Early Intervention Service Locations

Early Intervention Service Locations	Number of Groups (n=2)*
Schools	2
Churches	1
Communities	1
Grass-roots Community Organizations	1
Health Clinics	1
Homes	1
Hospitals	1
Parks and Recreation Centers	1

* Four focus groups did not provide preferred locations for early intervention services.

VIII. Barriers to Service Access and Strategies to Increase Access

Barriers to Service Access (Q7)

Focus group participants were asked “What keeps people from getting the prevention and/or early intervention services they need?” In response, Service Area 6 focus group participants focused largely on various access issues. **Table 9** shows that participants viewed barriers associated with stigma and discrimination, as well as barriers associated with costs, eligibility, and insurance as key service access concerns.

In addition, the high percentage of uninsured in the communities served by the focus groups, coupled by the high percentage of community members who may have insurance but struggle financially to meet other expenses, present considerable challenges to service access. Many families find themselves struggling between meeting mental health needs and meeting basic needs such as food and shelter. In this struggle, basic needs often take precedent.

“The mindset of our community is that they have been without for so long that they don’t open up to the services that ARE available. We as a community don’t embrace them.”

Stigma also plays a large role. Participants explained that cultural taboos and beliefs create the fear that if you seek mental health services you are “loco” or crazy. This is particularly true in the African-American, Latino, and Ethiopian communities.

Other access issues included the linguistic and cultural competency of service providers, transportation to and from services, the degree to which services are available, how accommodating providers are in terms of operating hours and child care, and the extent to which consumers trust the services they receive.

Another barrier to access that follows closely with the issues just discussed is lack of knowledge and awareness about mental health -- how it is defined, what are the risk factors, what services are available, and where to find those services. Specifically,

“And knowing there’s a way to navigate and there’s an open door because a lot of what I hear is ‘we don’t know where to go, and when we go, we don’t understand what they are telling us to do.’ So, a way to help them navigate through it, open doors, and know there’s a way to access it would help. Again, it goes back to information of being able to navigate it and open doors, and that they don’t have to wait three months to get the help they need. ”

participants cited communities' lack of awareness of existing services and resources, as well as the lack of outreach conducted to familiarize community residents with mental health services and resources.

Once community members identify and locate the mental health service they need, they often encounter a system that is difficult to navigate. Focus group participants cited the challenges of not only completing intimidating and cumbersome paperwork, but also of what questions to ask, who to call with questions, how to access referrals, what follow-up care is needed, and how to figure out next steps.

Other barriers to service access mentioned by focus group participants were:

- Community members' immigration status.
- Insufficient funding to maintain needed services.
- Cost of medications.
- Lack of school staff to provide basic mental health services such as counseling.
- Lack of competent and caring staff.
- Inability of consumers to complete treatment due to money, transportation, and "*unexpected bad situations*" and also the transient nature of some populations.
- Lack of support from family members.

Table 9: Barriers to Service Access

Access Barriers	Number of Mentions
Access Issues	32
• Cost/Insurance/Medi-Cal/Eligibility Criteria	9
• Stigma	9
• Geographic Locations/Transportation	3
• Service Linguistic/Cultural Competency	3
• Available Services/Capacity	2
• Service Operations	2
• General Service Access	2
• Trust	2
Outreach/Education/Awareness	6
• Available Services	4
• General	2
System Support/Assistance/Navigators	3
Immigration/Cultural Matters	2
Funding and Resources	1
Medication Issues/Management	1
School Issues	1
Sensitive Staff/Can Relate	1
Service Engagement/Benefits-Families/Parents	1
Support System	1
Other	3

Strategies to Increase Access (Q8)

As a follow-up to the question about service barriers, focus group participants were asked to discuss the types of strategies that would help people obtain access to the services they needed (see **Table 10**). A number of strategies and approaches to improve service access were identified and covered a range of areas: ways in which outreach, education, and awareness can play a role; suggestions for breaking down access barriers; approaches to improving collaboration; and, specific strategies aimed at engaging families in mental health services.

Focus group participants proposed several multi-faceted ways in which outreach, education, and awareness efforts can serve to improve access. One focus group underscored the need for a grassroots approach to any outreach and awareness raising efforts conducted in Service Area 6 communities. Along the same lines, another focus group felt the goal of any outreach and education efforts should be to provide information that will help people become self-sufficient, self aware, and an asset to the community. Means of reaching these goals centered on making connections with community members through culturally appropriate literature and communication. In addition to community members, focus group participants also wanted to outreach to and make connections with community leaders, teachers, law enforcement, and providers in other sectors and raise their level of awareness and sensitivity to the mental health needs of the residents in their communities.

“To get like a group of people in the church to have a specific training, certify them and then have them run the trainings within the churches, would I think, be an excellent idea. But I actually do like that idea about training a group of people to go out within the Ethiopian community. Ethiopian people go out and then train other Ethiopians to educate.”

Identifying strategies to address the access issues cited in the previous question (e.g., cost, eligibility, insurance, stigma, customer service, and linguistically and culturally appropriate personnel) was also important to focus group participants. Each of three focus groups stated that free services and less paperwork; better customer service and timely services without waiting; and, trained interpreters, individually and collectively, create better access. Participants also wanted to find ways to break down the taboos and stigma associated with mental health. They suggested using the HIV model in which individuals affected would come out and state “I have schizophrenia” instead of “I have HIV.”

Participants in a few focus groups felt that greater collaboration and team work among providers, but also among community-based agencies from different sectors, would widen the pathway to service access. They made the following specific suggestions: forming regional networks of community-based agencies, encouraging providers and schools to network together, and using teams of experts to evaluate and diagnose mental health issues.

In addition, focus group participants also were concerned about improving the level of service engagement in their communities. One of the main recommendations they made in this area was to offer food vouchers, movie tickets, or other economically appealing monetary incentives to encourage people to not only access services, but to follow-up, and comply with program and service prescriptions.

Other strategies cited by focus group participants revolved around:

- Improved training for social workers about available services, and, as part of that training, reinforcing the role of the social worker as an advocate for children.
- Creating and/or updating a directory of community resources and services in multiple languages.
- Increasing the pool of mental health professionals available to provide services.
- Holding service providers and communities accountable for servicing the mental health needs of communities.
- Providing better and more thorough evaluation, assessment and diagnosis.
- Offering local and easily accessible services.
- Reducing the focus on medication as a solution to all mental health issues.
- Developing a system of coordinated and integrated services.
- Establishing one-stop centers with extended hours.
- Helping community members complete paperwork, find services, and, in general navigate the system.

“... the social workers tell us that their job is to place the child into the home. Once they place the child into the home, they say it is okay, that their job is finished, but we got some problems ... and sometimes we know more than the social workers know.”

Table 10: Strategies to Increase Access

Strategies to Increase Access	Number of Mentions
Outreach/Education/Awareness	11
• General	5
• Linguistic/Culturally Appropriate Messaging	2
• Target Populations	2
• Specific Mediums	1
• Specific Locations	1
Access Issues	10
• Cost/Insurance/Medi-Cal/Eligibility Criteria	4
• Service Linguistic/Cultural Competency	2
• Service Operations	2
• Stigma	1
• Trust	1
Collaboration/Partnerships/Teams	4
Service Engagement/Benefits	4
Specific Strategies/Approaches	3
Staff/Provider Education/Training/Recruiting	3
Accountability	1
Assessment/Identification/Intervention-Early/Better Outcomes	1
Funding and Resources	1
Location-based Services	1
Medication Issues/Management	1
Service Integration/Continuity of Care	2
Specific Services	1
System Support/Assistance/Navigators	1
Other	5

IX. Recommendations for Informing Communities about PEI

Recommendations

When focus group participants were asked to provide recommendations on how to let people know about prevention and early intervention services, they focused entirely on various means of outreach, education, and awareness (see **Table 11**). Ways of conveying information about prevention and early intervention mental health services were heavily discussed, as were the locations at which the information should be distributed. In addition, focus group participants targeted their mentions to specific populations that they felt needed to be educated about mental health services.

Means of reaching out to and raising awareness among community members about mental health prevention and early intervention focused on using media, technology, and spokespersons. Types of media and their utilization included: 1) Messaging on television commercials and programs such as the Discovery Channel, MTV, Black Entertainment Television, and telenovellas; 2) Writing articles in ethnic newspapers, as well as in organizational and community newsletters; and, 3) Advertising on billboards and radio stations.

Forms of technology that could be used to reach out and educate communities about mental health and PEI included the Internet, and more specifically social networking sites such as MySpace, Facebook, You Tube, instant messaging, as well as text messaging. One focus group even suggested conducting a text messaging campaign about mental health.

Three of the six focus groups talked about engaging spokespersons to help raise awareness and reduce stigma. One of the three focus groups suggested hiring previous mental health program participants and youth as spokespersons, another suggested using primary care physicians as advocates, especially for the referral process, and the last of the three groups recommended involving a celebrity who represents the needs and the hopes of the community, like Magic Johnson, to lead a public awareness campaign.

Locations at which outreach, education, and awareness efforts should take place were numerous and varied, and included the following:

- Amusement parks;
- Block parties;
- Carnivals;
- Churches, and other faith-based organizations;
- City meetings;
- Concerts at venues such as the Staples Center;
- Grocery stores;
- Health fairs;
- Job fairs;
- Laundromats;
- Libraries;
- Parks;
- Restaurants; and,
- Schools.

As part of these efforts, half of the focus groups were specific about some of the target populations they felt could benefit from additional education about mental health services. Specifically, participants in these focus groups felt that social workers would benefit from some education about the mental health services that exist in the community. In addition, they recommended that social workers simultaneously learn how to become better advocates to their consumers. As with social workers, the focus groups also identified physicians as a population that communities need to connect with better. Among ethnic communities in Service Area 6, one focus group felt it important to inform the Muslim community, as well as transmit outreach messages to other parts of the country with Ethiopian populations.

A few additional mentions concerned communicating with families through parenting workshops and classes; conducting outreach using culturally appropriate materials, such as translating current materials into Ethiopian; and, using local residents to conduct public information and awareness efforts.

Table 11: Recommendations for Informing Communities about PEI

Recommendations	Number of Mentions
Outreach/Education/Awareness	44
• Specific Mediums	19
• Specific Locations	14
• Target Populations	5
• Families/Parents	1
• General	1
• Linguistic/Culturally Appropriate Messaging	1
• Other	3

“Promote mental health services in schools, because that’s the first place they see the problem with these children.”

X. Summary

The six focus groups from Service Area 6 were made up of a total of 51 participants. These participants considered Underserved cultural populations their top priority population and Disparities in access to mental health and Stigma and discrimination their top mental health needs. When asked to identify existing prevention and early intervention services, between one and three focus groups stated that either the PEI services are difficult to identify or that they are non-existent in their communities. Nevertheless, they identified a number of existing services, which was then followed by the identification of an even longer list of needed services. From the prioritization of these lists emerged (1) prevention services that strive to reduce stigma and discrimination; expand outreach, education, and awareness; and provide community-centered services; and, (2) early intervention services that strive to provide geographically accessible and affordable services for low income families; ensure ethnically and culturally appropriate services; and better address and meet the needs of the community through expanded services. Suggested locations for these services were community-based such as churches, grass-roots community organizations, health clinics, hospitals and the like.

Key service access concerns cited by the focus group participants were stigma and discrimination (as reflected in the top mental health needs), costs, eligibility, and insurance. Correspondingly, strategies to increase access involved free and timely services, less paperwork, better customer service, and trained interpreters. Focus group participants also underscored the need for a grassroots approach to the areas’ outreach, education, and awareness building efforts as another means of increasing access to services. They also recommended targeting specific populations that they felt could benefit from additional education about mental health services. Specifically, they advocated for outreaching to and connecting with social workers, physicians, and the Muslim and Ethiopian communities.

APPENDIX A

APPENDIX A: Focus Group Guide

FOCUS GROUP QUESTIONS

Issues	Focus Group Questions
PEI Planning Process	1. Have you or your group taken part in the Los Angeles County Department of Mental Health's (DMH) Prevention and Early Intervention (PEI) planning process? If so, how?
Participants' Organizational Affiliation	<p>These focus groups help us learn more about the types of mental health services and resources that are needed to support the social and emotional well-being in your community and among other groups of people in L.A. County.</p> <p>2. Which region or area in L.A. County do you represent or will you be talking about in today's discussion?</p> <p>2a. Of the identified priority populations [<i>facilitator refers/points to visual aid listing priority populations</i>], which of these groups of people do you represent?</p>
Community Mental Health Needs	<p>The California State Department of Mental Health said that the Prevention and Early Intervention (PEI) plan should focus on the needs of the following groups: at-risk youth, people who may be at risk of suicide, people who haven't been able to get services, and people who have experienced trauma, stigma and discrimination.</p> <p>3. What needs are most important to the group of people you represent?</p> <p>3a. <i>Of the needs that you've listed, which are the top three needs most important to your community?</i></p> <p>4. What do you see happening in your community because of these needs? (what problems are occurring?)</p>
Prevention and Early Intervention Services	<p>As we talked about earlier, there is a difference between prevention and early intervention services [<i>facilitator refers/points to visual aid defining prevention and early intervention</i>].</p> <p>5. What prevention services or resources are currently available in your community or among the group of people you represent?</p> <p>5a. What prevention services or resources are needed?</p> <p>5b. <i>"Of the prevention services you've listed, which are the top three needed."</i></p> <p>5c. <i>Facilitator probes for information on locations for services.</i></p>

APPENDIX A: Focus Group Guide

Issues

Focus Group Questions

6. What **early intervention** services or resources are currently available in your community or among the group of people you represent?
 - 6a. What **early intervention** services or resources are needed?
 - 6b. *Of the early intervention services you've listed, which are the top three needed in your community?*
 - 6c. *Facilitator probes for information on locations for services.*
7. What keeps people from getting the prevention and/or early intervention services they need?
8. What types of things or strategies would help people get the services they need?

*Long Range
Planning*

9. What recommendations do you have for how to let people know about prevention and early intervention services?
-